"People
helping people
help
themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

DIVISION OF DISABILITY & REHABILITATIVE SERVICES
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To: Consumer, families, providers, case managers and stakeholders who support individuals with disabilities

From: Peter A. Bisbecos, DDRS Director
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Re: **Questions and Answers, Resources and the Latest Information about the System Transformation**

Date: December 24, 2008

The information provided in this bulletin has been compiled by the Division of Disability and Rehabilitative Services (DDRS) to answer common questions about the Objective Assessment System for Individual Supports (OASIS) and provide resources to assist you during the system transformation. This is our response to the questions submitted during the recent statewide presentation on December 17, 2008 and submitted to the OASIS-ICAP Help Line in the past few weeks. DDRS will release information in the form of bulletins, presentations, and videos to continue this ongoing dialogue.

We have made every attempt to organize the information so that it is a useful resource to refer to when you have questions in the future. Where applicable, we have also included references to important links and previous bulletins. If you do not see the answer to your question in this bulletin, please feel free to contact the OASIS-ICAP help line for more information:

OASIS-ICAP Help Lines: (317) 234-5222 or 1-888-527-0008
E-mail: OASIS-ICAPHelp@fssa.IN.gov
Website: www.ddrs.IN.gov

The changes we are making will help people with disabilities to achieve their hopes and dreams. Moving toward implementation, open collaboration becomes increasingly important. We thank consumers, families and stakeholders who support individuals with disabilities for continuing to partner with us in the process.

Thank you.

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When listing a slide number in the Q & A tables below, we are referring to the slideshow presentation from December 17, 2008. This Power Point slideshow has been posted on the DDRS website, at http://www.in.gov/fssa/ddrs/3350.htm. In addition, we have posted the links to recent bulletins and other documents relating to OASIS and the system transformation below.

RESOURCES:

1. BQIS online: http://www.in.gov/fssa/ddrs/2635.htm
2. Bulletin Links: http://www.in.gov/fssa/ddrs/3350.htm
    - DDRS System Transformation Announcement (OA20081107)
    - OASIS Invoicing Tool Webinar (OA20081102)
    - OASIS Presentation (December 17, 2008)
    - Group Log Sample (OA110708)
    - OASIS Statewide Presentation Web Link (OA20081212)
    - OASIS System Transformation Presentation Announcement (OA20081209)
    - OASIS System Transformation Slide Show (OA20081219)
    - RHS Rates, Definitions and Standards (OA20081124)
    - Service Definition and Documentation Standards (OA20081107)
3. INARF: http://www.inarf.org/
4. Indiana Association of Behavioral Consultants (IN-ABC): http://www.inabc.org/
5. Interactive Budget Tool and Invoicing Tool: https://ddrsprovider.fssa.in.gov/BDDS
6. IPMG (Case Management): http://www.gotoipmg.com/index.php
7. Self-Advocates of Indiana: http://www.saind.org/
8. The Arc of Indiana: http://www.arcind.org/Default.htm

TOPIC: ALLOCATIONS

QUESTION	ANSWER	RESOURCE
Will the OASIS allocation referenced in the previously provided information be based upon the results of the ICAPs?	Allocations include ICAP information and other addendum factors.	• Slide 13
Have the results of those allocations that have been completed been shared or reviewed?	Not yet, DDRS is currently working on the release of allocations for consumers with annuals in April.	• Slide 57
In multi-person living arrangements, how does the state want teams to handle situations where the site has enough dollars in the collective plans, but there is not team agreement on the allocation of the dollars across the plans.	Consumers and their teams work together to identify the services needed. This includes review of the PCP, ISP, and "Usual and Typical". If an agreement cannot be reached then the support team can consider guidance from the local BDDS Office, BDDS Field Service Directors, DD Ombudsman, and the Director of Client Services. If a decision is not made by the end of the current approved plan, services will be auto converted to the "Usual and Typical" until a decision is reached.	
On January 1, 2009, will the cap for the Support Services (SS) waiver increase from the current $13,500 to $16,000, if this is when the consumer's budget comes due?	No. DDRS is will seek an amendment to increase the annual cap on the Support Services waiver to $16,000 and will keep you updated on our progress. The $13,500 cap remains in effect until an amendment to waiver is approved by Medicaid.	• Slides 57 • Bulletin, 11-7-08, Pages 1 & 5 • Bulletin, 11-24-08, Page 2
What will happen if a provider bills down a consumer's entire allocation amount and then the consumer chooses to change providers?	Providers may not pre-bill for services. Services must be rendered to prior to reimbursement. If a plan has been pre- or over-billed, please notify your local BDDS office.	
When will OASIS allocations be determined and when will the consumer and provider be notified? What is the appeal process?	Ideally, each consumer will have their allocation 100 days prior to their annual renewal date. Allocations are not appealable. The team is expected to work together to develop a plan. If they cannot agree on a plan within the allocated budget, the consumer may invoke the standard review process by contacting the local BDDS office. A consumer may appeal an approved or denied NOA/CCB. Instructions on how to appeal and begin the appeal process are provided with the NOA.	

TOPIC: ANNUAL PLAN TO OASIS TRANSITION

QUESTION	ANSWER	RESOURCE
My son is on the Developmental Disabilities (DD) waiver. Will he get fewer services due to the OASIS process?	OASIS is comprised of an objective assessment process, a resource allocation model, and standardized reimbursement rates. The purpose of OASIS is to transform the system is to focus on fair and equitable access to services for all consumers in Indiana that is based on consumer choice and family advocacy. In the past, budgets were often based on the strength of an individual's advocacy. With OASIS, allocations are based upon the needs of the individual. Consumers will partner with their support team to develop a plan for services that will best meet the consumer's goals and desired outcomes within the limit of the allocation amount. The earliest any current waiver consumer will use an OASIS allocation is April 2009. DDRS is putting a transition plan in place to assist when a budget increases or decreases. We will release a bulletin about the process of Transitioning to OASIS when this information is finalized.	
For an existing DD waiver individual who has an annual plan date of 10/01/09, would we bill his old daily rate from his current annual plan for the months of Jan09 through Sept09, or would we bill using actual units of service and the newly developed uniform rates? Same question for an existing SS waiver individual who also has an annual plan date of 10/01/09?	Yes. Consumers will stay on annual plan until their annual review date.	• Bulletin, 11-7-08, Page 5 • Bulletin, 11-24-08, Page 2
A person with a Notice of Action (NOA) expiring in January 2009 may be considered to have excess annual amounts, but the person who has an NOA expiring in May (who will have their annual amount set by the assessment method.) Should all	Each consumer should have an independent review of their needs using their allocation. In the event that shared staffing needs to be considered in the individual planning process, the teams for all consumers may need to review	

plans be adjusted now and all may be adjusted again in May?	plans and adjust as necessary.	
When will I know my allocation? How will I be notified?	Your case manager will provide you with the budget figure, and then you should begin to see what services you may purchase within the allocated amount. In most cases, allocations will be available 100 days before a consumer's annual plan review.	

TOPIC: COMMUNITY HABILITATION

QUESTION	ANSWER	RESOURCE
Are there any exceptions for the 25-hour a month cap on Community Based Habilitation-Individual (1:1)?	No. This is a Federal agreement for the DD and Autism waivers. On the SS waiver, a consumer may receive more than 25 hrs a month.	
If an individual MUST have 1:1 ONLY service and is currently receiving more than 25 hours per month, how do you go about appealing this?	There is no appeal for this since this part of our agreement with the federal government. The consumer may consider buying other day services, or utilize group community activities, for which there is no limit (except the consumer's allocation amount).	

TOPIC: GENERAL & MISCELLANIOUS

QUESTION	ANSWER	RESOURCE
Category: Hospital Stays Hospital and when a consumer goes to Day Service; if either requires/demands that staff stay, what will options be to providers since that time is not billable? In Day program, can we bill time since we are providing 1:1 staffing? (this is rare, but program asked, so I guess there have been some instances of this occurring)	An RHS or day service provider may not bill for services to a consumer who has been admitted to a Medicaid licensed facility.	• DDRS Quarterly Bulletin, 3rd Quarter 2007, 1-3-08
Music Therapy Services Is consideration being made to increase the rate for Music Therapy Services? It is becoming increasingly difficult to provide in-home services at the current reimbursement rate, considering mileage costs to outlying areas we are serving.	Currently Music Therapy is not under consideration for a rate increase.	
Music Therapy Services Day providers are indicating	Medicaid Waiver approved Music Therapy can happen in any non-	

individuals must be in program from 8 a.m. to 3 p.m. daily for the providers to utilize their full rate. This leaves little time for music therapy which Individuals need and want. Can Individual Support Plans be more flexible to allow for Music Therapy?	school based environment. The team determines where and when services are to be rendered.	
Thank you for having the satellite locations. However, it was very difficult to read the Power Point presentation. It would be nice if you could at least e-mail it to us prior to the Event so that we could bring it with us if it is not going to be provided at the event.	Thank you. It is our goal to provide Power Points in advance of the presentation when possible. When available, the document and other materials will be posted online and the link will be sent in a bulletin.	

TOPIC: ICAP & ADDENDUM QUESTIONS

QUESTION	ANSWER	RESOURCE
A consumer plans to leave school in May of 2010 when her younger sister graduates. She will be 19 on 1-5-09. Her next annual is in July with a CCB start date of 9-1-09. When should we request an addendum update since leaving school is a qualifying event?	The consumer does not need an addendum update. Age will be the only changing factor for now, which is an automatic update. The time to request an update is when you know the date she will actually leave school.	• Slide 16
How is it determined who gets interviewed for the ICAP? Do mental health providers who see folks regularly get involved in interviews?	A respondent should see and interact with a consumer an average of 3-5 times a week. Mental health professionals usually do not have this contact, but may be used in the absence of other appropriate respondents.	• Slide 11
What assurances are in place to address the amended questions or additional questions with the ICAP process? Some Case Managers are not responding when asked if this had been completed.	All consumers who have had an ICAP should have had addendum questions asked. We cannot develop an allocation without both the ICAP scores and answers to the addendum questions. Please contact the OASIS-ICAP Help Line if you think this was not done.	• OASIS-ICAP Help Line

TOPIC: INTERACTIVE BUDGET TOOL

QUESTION	ANSWER	RESOURCE(S)
Is the Interactive Budget Tool available to use?	Yes. See link (at right)	• Slide 22 • http://ddrsprovider.fssa.in.gov/BDDS/Utilities/CustomerBudgetList.aspx

TOPIC: INVOICING TOOL

QUESTION	ANSWER	RESOURCE
When will the invoicing tool be available to create sites in preparation for January billing?	Invoicing tool is now available to create sites for billing in January.	• http://ddrsprovider.fssa.IN.gov/BDDS
If a person on the DD or AU waiver lives with a person on the A&D or TBI waiver is use of the invoice tool "required"? If so, is the invoice amount produced for each person what is required to be invoiced regardless of the waiver type, or is the amount invoiced only applicable for persons on the DD and AU waivers?	The Invoicing Tool is used for all consumers sharing RHS staff regardless of the funding stream. For example, a consumer on the Developmental Disabilities (DD) waiver and a consumer on the Traumatic Brain Injury (TBI) waiver live together and share staff, both consumers should be entered into the Invoicing Tool. The consumer on the TBI waiver's invoicing result will be zero because they have a different billing methodology under the Division of Aging. Conversely, if these two consumers live together, and only share living expenses such as rent and utilities, then the consumer on the TBI waiver does not need to use the Invoicing Tool. Only use the Invoicing Tool if the consumer's share staff.	• Bulletin, 11-7-08, Page 6
Define "shared services" and/or "shared staff". There are many situations where persons live together sharing living expenses, but not sharing RHS services. Is the use of the Invoicing Tool required in these situations?	Shared staff refers to sharing RHS staff, not sharing living expenses. The use of the Invoicing Tool is only required for individuals sharing staff, regardless of funding stream.	• Bulletin, 11-7-08, Page 6
Regarding the enrolled days that we need to enter in the invoicing tool, do I use the number of days in the month for enrolled days? If not, where do I find this information?	If a consumer receives 24-7 coverage with you, or you provide services daily it is the full month. If services are provided only on weekends or sporadically, enrolled days equals number of PLANNED DAYS served. Attendance always equals actual days served.	

TOPIC: PLANS OF CARE (POCs) & COST COMPARISON BUDGETS (CCBs)

QUESTION	ANSWER	RESOURCE
Am I correct to assume we will receive new CCBs for everyone? When will this occur?	The new CCBs with uniform rates will be for those in BDDS District 4 only. BDDS began sending new NOAs electronically as of 12-8-08. The auto-conversions for January	• Slides 53 and 58 • Bulletin, 11-24-08, Page 3

	renewals and updated NOAs removing the flexibility factor will be sent the week of 12-22-08.	
Have there been a lot of changes in service levels?	DDRS recently finalized all rates. The next step is to compile the ICAP information and addendum factors to develop the individual allocations. Until this process is completed the individual allocation levels are not known.	
To maintain the consumer's current level of support, costs may exceed the current CCB/allocation. For these consumers, case managers will submit the plans for review by the BDDS waiver unit. How long will it take the waiver unit to approve/disallow an increase?	Plans for January to March renewals will use the current approved CCB amount as the allocation amount. If the new plan is within the current CCB amount, the waiver unit will approve as quickly as possible. If the plan submitted is over the current approved annual CCB amount, the plan will be returned to the case manager for a second review.	• Slides 54-55
In the interim, are providers expected to continue to with the higher level of support until the decision is made? If so, will providers be permitted to bill for services rendered?	Providers should render and bill only for services that have been approved as stated on the NOA.	• Slides 49, 53, 54
If consumers need to stay longer with their family and it saves money, can I use the savings to support my son when he wants to move out on his own in supported living with RLA?	The OASIS allocation is good for one year. "Savings" experienced can only be utilized within the plan year. Carry-over of unused funds year-to-year is not allowed. However, your next year's allocation will not be reduced based on under-utilization during the previous year.	• Slide 14

TOPIC: PRIOR AUTHORIZATIONS (PA)

QUESTION	ANSWER	RESOURCE
Assuming that the PA is for Facility Group Habilitation in total, if the Service Planner says 6:1, can I provide 4:1 or 6:1 or 8:1 and still bill it against the authorization for Facility Group Habilitation?	PA for this example is for Facility Group Habilitation and based upon a ratio of 6:1. The provider may render services at a different ratio level (4:1, 6:1, or 8:1). The provider must use the correct modifier for that ratio and supply Service Notes and Group Logs that support the service(s) rendered.	• Slides 71 and 79 • Bulletin, 11-7-08, Page 7, see sample document provided.
Was the example that we could request from the Bulletin on November 7, 2008 a valid example? If not, can a valid example of what documentation is being required be	DDRS does not require providers to use a standardized document. DDRS provided conceptual documents which captured all necessary elements required for	• Slide 78 • Bulletin, 11-7-08, see sample document provided.

provided?	documentation. Each provider is responsible for creating their own system.	
What will happen when an individual switches providers in the middle of their PA? I had to deal with several other companies whom had overbilled until the day we received the individuals, and then we were underpaid for our services, because PAs were exhausted. I was able to get some of the providers to go back and adjust their billing claims, but some of them of course are not willing to cooperate and it seems like neither the case managers nor the service coordinators can do anything about it. Please tell me if this is going to be any different under OASIS.	Under OASIS there will be NO MORE pre-billing for services allowed. Only services already provided may be billed. This should help protect the PA.	Bulletin, 11-24-08, Page 4.

TOPIC: REIMBURSEMENT RATES & BILLING

QUESTION	ANSWER	RESOURCE
How should the provider bill for time when a consumer is in a quarterly or annual meeting with the team?	To bill for direct care staff time, providers must document that staff and consumer were both present and complete a Progress Note to verify the service(s) rendered.	• Slide 79
What if the staff person is providing an allowable activity "non face–to-face" or "indirect"? If the unit is face-to-face, please explain how to document and claim reimbursement for activities pertaining to the allowable activities (particularly those relative to monitoring, training, coordinating, and facilitating.)	To bill for direct care staff time, providers must document that staff and consumer were both present and complete a Progress Note to verify the service(s) rendered. Non-face-to-face time is billable for SEFA and Therapies, i.e. Behavior Management Services. For example, the time a supervisor is working direct care is billable time. But indirect supervision time (i.e. reviewing paperwork, signing timesheets, etc.) is not billable time.	• Slides 75 • Bulletin, 11-7-08, Page 7
Electronic payroll systems capture a work hour. If staff shows up at 8:00 p.m. to work a shift but the consumer does not return from the parent's home until 9:00 p.m., may the provider bill for that time?	No. To bill for direct care staff time, providers must document that staff and consumer were both present and complete a Progress Note to verify the service(s) rendered.	• Slide 79 • Bulletin, 11-7-08, Page 7 • Bulletin, 11-24-08, Page 7
At a previous training, we were told that attendance would be at the top	Hours can be billed in fractional units.	• Slides 75 and 78 • Bulletin, 11-7-08, Page 7

of the hour and we were under the impression under this system you could claim for the whole hour. The DDRS Bulletin dated 11-7-08/page 7 says that fractional hours are allowable and should be used when consumer is in service for less than one hour (example: 2 hours 50 minutes = 2.833 hrs.) Please clarify that we have to document to the minute and that we can't round to the nearest half hour or quarter hour?		• Bulletin, 11-24-08, Page 7
If a consumer starts the day at a day service facility, then goes into the community and returns to the facility to end their day, can the whole day be considered facility based?	No. If a consumer transitions to another discrete service, a separate Progress Note for each discrete service and billing is required to reflect the service change.	• Slide 74 • Bulletin, 11-7-08, Page 7
For the purposes of calculating the persons average quarterly wage, please clarify if the wage should be calculated based on the number of hours the person participated in Pre-Vocational Services or the number of hours the consumer received Pre-Vocational Services and was compensated. For example, if an individual worked 3 hours in compensable work and then 3 hours in simulated work, should we use 6 hours or 3 hours in the average wage calculation?	Calculations should always be made on time in service regardless of productivity or wage levels.	• Bulletin, 11-24-08, Page 8
Our question pertains to lunch in the Pre-Vocational Services setting. We are present to provide support and supervision during the lunch hour and find it necessary to do so. Since we take attendance at the top of the hour, ratios are maintained on the Group Log but are not maintained in the actual lunch room in that training is not provided during that time and clients do not need the same level of support and supervision as they do during training times. Is this considered billable time. Our concern is that if we cannot bill for that time, then we should not be expected to provide the service for free and	No provider is expected to provide services for free. Lunch time is a billable activity. It may be billed as Pre-Vocational Services, Individual or Group Habilitation Service. Supervision at the appropriate claimed ratio is expected.	

should be held harmless for any event which may befall a consumer during the lunch time. If this is not billable time, is it the state's intent that we not provide supervision during the lunch time? One Case Manager wanted to deduct lunch hours from the service planner. Please provide clarification on the lunch issue.		
How should the time be recorded and billed for restroom assistance? Some restroom assistance situations require significant staff time.	If a consumer requires extensive supports for restroom assistance on a regular basis, this time should be planned for when developing the Person-Centered Service Planner.	
If a consumer is in SEFA/Tier II (typically receives between 6 - 10 hours of services per month), but only receives 3 hours of service during a particular month, do we bill hourly instead of the Tier II monthly reimbursement rate?	If a consumer is provided SEFA services outside of the Tier, the provider should calculate the actual hours rendered by the hourly rate ($35.19) and bill the hourly amount utilizing the code for their assigned tier.	
If a person is in SEFA/Tier I (typically receives between 1 - 5 hours of services per month), but receives 9 hours during a particular month, are we able to get paid for the additional hours of support or do we only bill for the Tier I monthly reimbursement rate?	See above.	
If a consumer does not use all of their services in one month, then will the services roll over to remaining months?	All dollars are available for expenditure during entire plan year. Plans will need to be updated when moving unit month to month.	• Slide 14
We need to get some consistency and time in service provision. All this change is affecting families and consumers. My son is almost in tears at his meetings worrying about his services getting cut. Will this change stay in place for a while or will it change from year to year?	OASIS is expected to replace the current waiver system. The basic premise will not change. Based on dollars available in the biennium budget for services, definitions and rates are subject to change.	
If an ISP is not able to be signed by a provider due to a non-agreement of the services being able to be provided in the plan, is the 60-day discontinuation waived?	No. The provider is expected to render services and must provide 60-day termination notice as per current policy. A provider is not expected to provide any services not listed on the NOA. If a plan is auto-converted, the team has the ability to make an update to plan, and redistribute the available	• Slide 53

	dollars.	
Will rates change on the community support budgets?	Currently, there is no plan to adjust State Line rates.	
If in providing Pre-Vocational Services at a 1:16 ratio and we are having staff provide a 1:8 ratio, will allocations change for the consumer to support the lower ratios?	Consumers will purchase to the level of service they desire and can afford. Not everyone will be able to receive a ratio of 1:8. Teams and providers may need to adjust groups sizes based the purchasing power of their consumers.	
How can you bill one service monthly (SEFA) and other services weekly?	Because of the ranges allowed in SEFA which provide tremendous provider flexibility, this service must be billed on a monthly basis. Other services can be billed daily, weekly, or monthly. It is provider choice.	
For consumers who are on OASIS, will the billing be submitted through EDS or the State (DDRS) billing program? We have no residential consumers just Pre-Vocational, Day Services, Facility Habilitation, Behavior Management, SEFA, Community Habilitation and Transportation.	Medicaid uses EDS as the fiscal intermediary for billing. State Line services utilize the community budget system.	

TOPIC: RESIDENTIAL HABILITATION SERVICES (RHS)

QUESTION	ANSWER	RESOURCE
Please clarify which definition of RHS (waiver manual versus bulletin - November 24) supersedes which?	The Service Definitions have not changed for RHS. The definition listed in the manual and the definition referenced in the bulletin are the same. Only the rate and manner of reimbursement have changed. The distinction of 35 hours above and below has been added.	• Slide 59 • Bulletin, 11-24-08, Pages 9 & 10
Is the RHS billable unit "staff time, face-to-face" and if so, does this mean that when a staff person is providing an allowable activity face-to-face that this time is billable?	Yes. In order to bill for services the consumer and staff must both be present and then a progress note written to verify the service(s) rendered.	• Slides 75 and 79 • Bulletin, 11-24-08, Pages 9 & 10
May a provider record that a staff person on duty from 9:00 a.m. to 9:15 a.m. was there for an hour?	No. this would be billed as 0.25 hour.	• Slides 79 and 80 • Bulletin, 11-7-08 • Bulletin, 11-24-08, Page 7
On the RHS documentation standards, when they refer to "one entry" does that mean each staff person writes a narrative and individually signs or can one entry be made and both staff sign the one entry?	One entry can be written by one staff and other staff can sign if the entry completely covers both staff's activities and shifts.	• Slide 75

Listed under allowable activities for RHS-1 and RHS-2, in the DDRS Bulletin, 11-24-08, page 9, there is a section regarding "coordination and facilitation of medical and non-medical services to meet healthcare needs...etc." If a Supported Living Nurse documents when she completes this task, can we bill for her time? If this is allowable, since much of this is indirect care time for a nurse, which seems to make it billable. Does this conflict with Documentation Requirements, bullet point 3 on pg. 8 "All staff members who provide uninterrupted, continuous service in direct supervision of care of the consumer…?	Nursing services are part of the services included in RHS. Therefore the nurse's care time is not billed separately when provided in conjunction with RHS, as described in this example.	• Slide 59
If providers must manually track hours, do we bill fractional hours for RHS?	Yes. The billing system used by DDRS' fiscal intermediary (EDS) accepts fractional units.	• Slide 80 • Bulletin, 11-7-08, Page 7 • Bulletin, 11-24-08, Page 7
Is the rate for RHS (e.g. RHS-1 = $25; RHS-2 = $21) defined in the plan or based on actual utilization? For instance, the person's plan is for 40 hours/week of RHS and therefore the rate in the plan is $21.00; However one week the person only uses 30 hours of RHS…should we bill those hours at the plan rate ($21) or based on utilization ($25)?	The rate will be determined by the information entered on the consumer's Person-Centered Service Planner.	• Slide 79

TOPIC: RESPITE CARE SERVICES

QUESTION	ANSWER	RESOURCE(S)
1. Can Respite Care Services be provided at an Adult Day Care facility which is not a day service facility?	No. Respite care services may only be provided in the individual's home or place of residence, in the caregiver's home or in a non-private residential setting (such as a respite home) or camp setting. However, a provider may offer Facility Habilitation-Individual or Group services.	• Bulletin, 11-24-08, Page 6
2. The new service definition states that Respite Care Services "can be provided in….or in a non-private residential setting such as a respite home." We take this to mean that we cannot use our day	See above.	• Bulletin, 11-24-08, Page 6

service facility since this is not a residential setting. Is this interpretation correct or is it possible to deliver respite services using our day service facility?		

TOPIC: SERVICE DEFINITIONS, DOCUMENTATION STANDARDS & AUDIT

QUESTION	ANSWER	RESOURCE
I received a letter stating that monthly summaries are to be completed "until further notice". Since documentation standards are changing, are monthly summaries still necessary?	Yes. Completion of Monthly Summaries will continue to be required.	• Slide 75 • Bulletin, 11-24-08, Page 7
If the monthly summaries remain a requirement could the completion of them be considered a billable, allowable activity (monitoring)?	To bill for reimbursement, providers must document that staff and consumer were both present and a complete Progress Note to verify the service(s) rendered. IPMG and INARF are currently working together to revise the monthly summary into a standardized document where providers will be able to report an individual's progress toward goals and outcomes.	• Slides 75 and 79 • Bulletin, 11-7-08, Page 7 • See also the second question above in *Reimbursement Rates and Billing* section
IF the ISP indicates that services are not being shared is that sufficient for audit purposes to verify why the invoicing tool was not used?	Yes.	• Slide 79
Is HSPP supervision still a requirement?	Yes.	
Does behavior management switch to hourly billing for everyone on January 1, 2009 or will it switch as annuals are renewed?	Behavior Management will move to quarter hour billing for consumers who have annuals starting January 2009.	• Bulletin, 11-7-08, Page 3
In accordance with the Service Definitions and Documentation Standards published on November 7, 2008 is it correct to assume that signature on the Service Note is sufficient to document for services rendered and are not required for Group Logs.	Staff names and signatures are required on Progress Notes. Staff names are required on Group Logs; however, staff signatures are not required.	• See documentation standards from Slides 74 and 75 • Bulletin, 11-7-08, Documentation Standards and Example of Group Log
In regard to tracking and billing of day services, if you use an exact time in/out tracking system will the report generated from the system suffice for the Group Log? (See	As an alternative to the Group Log, you may use a time in/time out methodology for each group. A Group Log must be generated and should count the number of	• Slide 78

attached Time In/ Time Out Worksheet)	individuals served during each time block during the day. If the generated report contains all the required information for a Group Log as outlined by the Service Definitions, then it will suffice as the Group Log. Under time in/time out, the in and out times of each person served is recorded in a manner consistent with the Service Notes. If the consumer leaves the group to receive other billable services or leaves the agency, then they would be considered out of the group and a time out would need to be recorded.	
Can two groups be documented on one log sheet? For example, if you have 2 staff and a Pre-Vocational Services group size of 18, may we document one 8:1 ratio group and one 10:1 group on the same log?	The largest group for Pre-Vocational Services is sixteen (16). In the example, the provider should be able to distinguish which staff served which consumers to achieve the ratios. A Progress Note must also support this information.	• Bulletin, 11-7-08, Pre-Vocational Service Definitions and Allowable Ratios
In the above scenario, does each staff person have to document the notes for their caseload or can one staff person document the Service Note for all?	The staff delivering the direct service is the person who is expected to provide documentation and sign the Service Note. The Service Note must meet all of the requirements outlined in the Service Definitions and cover activities rendered during the specified time period.	• Slide 75
Based on the Service Definitions we interpret that an hourly Group Log is required. Some providers believe that hourly Group Logs are not mandatory and only need to be documented if the ratio changes throughout the day. Is a "top of the hour" log required EVERY hour no matter whether or not the ratio has changed?	Group Logs are required for all group services (i.e. Community Group, Facility Group and Pre-Vocational Services.) Documentation may begin at the top of the hour or as determined by the agency. The basis for the staffing ratio will be the greatest number of consumers in services during the time period claimed. You may take attendance as often as you like. If the group size remains the same for the entire day then the Group Log will not change and the same	• Slides 75 and 80 • Bulletin 11-24-08, Page 7

	staffing ratio would be billed for the entire day for that group. You would still need to do a Group Log throughout the day in accordance with the methodology that your agency is using. Billing is based upon the actual time served per the Service Note and the group size of the services delivered per the Group Log. Billing may occur in fractional units.	
If 2 staff and 8 consumers are present at 8:00 a.m., the top of the hour group size is 4:1. Then at 8:15 a.m., one staff leaves but returns at 8:45 a.m., do I bill one hour at 4:1 for each consumer?	Billing must reflect the service provided. Providers must document that staff and consumer were both present and a complete Progress Note to verify the service(s) rendered. To bill for reimbursement, providers must document that staff and consumer were both present and a complete Progress Note to verify the service(s) rendered.	
Do the required two monitoring contacts each month for SEFA individuals have to both be face-to-face visits? For example, can one face-to-face visit be made and the second contact be a phone call instead of a face-to-face visit?	Yes, both visits must be done at the consumer's job site. The Service Definitions must be followed.	Bulletin 11-7-08, See Service Definitions and Documentation Standards, Allowable Activities for SEFA.
Can consumer Service Notes be completed electronically with staff name typed or does the document need printed so that the staff may sign with a live signature?	E-signatures are fine as long as you have an internal policy regarding E-signatures and maintain a log of actual signature in a master file.	
Is the audit trail still going to be time sheet to daily note? What has been communicated to Health Care Excel (HCE) as far as audits?	Yes, with RHS. The audit trail for days will be a timecard, notes and logs. As with all audits, any documentation a provider may present may be considered.	
How should "face-to-face" be written up for night staff in a home that will withstand audit?	Staff time cards and a Service Note will be reviewed. Other documents (i.e. incident reports) may be reviewed as well.	
One area that was questioned was breaks and do they need to be broken out on the timecards?	Consumer breaks are considered a part of the service. Do not change services or reduce your ratios because of consumer break time.	
Is cleaning up afterward part of a job. I thought that this time should be billed to Pre-Vocational Services.	Consumers assisting in cleanup can be considered as part of the job and can be a billable activity when both	

	staff and consumer are present.	
We have consumers who help make deliveries as part of their Pre-Vocational activities; do we bill Pre-Vocational Services at 1:1 or 1:2?	Pre-vocational Services do not go below 1:8. Providers must use Facility Group or Community Habilitation for this service.	Bulletin 11-7-08, See Service Definitions and Documentation Standards.
Has it been determined what the auditors will require on documentation? Have they been involved in this process?	DDRS staff will educate auditors on the expectations of the provider community prior to any audits being conducted. Please see Service Definitions for Documentation Standards. In most cases the audit will consider, but is not limited to, a review of progress notes, group logs, other documentation (med sheets, incident reports), claims and information to and from EDS.	
Can an entire week or month be on a sheet or is it a new sheet daily for each individual served?	Each block of time for an individual service requires a separate entry on the Service Note. A single, continuous Service Note is acceptable as long as the Service Definitions and Documentations are met.	
How do we document the names on the group LOC to avoid a violation of confidentiality? First initial, last name, middle initials only, or some other way?	There is no protected information expected on a Group Log, other than the consumer names. These documents are for agency and state review only, and therefore it is not a violation of HIPAA. You may use unique identifiers if you choose not to use names. Please have an internal policy and procedure for assigning these names for ease at future reviews.	

TOPIC: SERVICE PLANNER

QUESTION	ANSWER	RESOURCE
Will there be a way for the case manager to forward a copy of the completed Service Planner to the providers, for review, to ensure that it is correct before submitting the CCB to the waiver unit?	There is no way to get a copy of the Service Planner to you immediately, but you should leave the meeting knowing what is going to be entered into INSITE. If you feel the resulting Service Planner is in error, please contact your case manager for a resolution.	
As a provider, when providing RHS hours to a Case manager for a	The new Service Planner will allow you to capture all types of ratio	• Slides 61-68

client's service planner, do we break down the hours? *EXAMPLE*: If on Monday Andrew has staff 24 hours and he shares those hours with one housemate, do we submit to the Case Manager 24 hours at 2:1 or break down to 12 hours for Andrew in a 2:1 ratio?	scenarios potentially experienced in a given day for any consumer. If you are using the pre-OASIS Service Planner, you will need to state the hours used as 1:1. In this scenario you would ask for 12 hours.	
Do day services ratios need to be in place on January 1, 2009 or April 1, 2009?	Ratios are needed on any plan going to uniform rates on January 1, 2009 and thereafter.	• Bulletin, 11-7-08, Page 5 • Bulletin, 11-24-08, Page 2
Does the OASIS planner need to match the NOA?	A Service Planner should ALWAYS reflect the typical planned week a consumer is to receive services. If that underlying typical planned week changes, an update should be made for plans moving forward with uniform rates.	

TOPIC: SHELTERED WORKSHOPS, PRE-VOCATIONAL SERVICES, AND SUPPORTED EMPLOYMENT FOLLOW-ALONG (SEFA)

QUESTION	ANSWER	RESOURCE
The choice between Pre-Vocational Services and Sheltered Work will be determined quarterly, so how does this factor into the NOA and is the same Invoicing Tool used?	The Invoicing Tool is not used for day services. The team determines quarterly which services are to be used. Pre-Vocational versus Sheltered Employment services is determined by the following process: Divide the previous quarter's gross earnings for each service by the hours of attendance for that service. If the hourly wage falls below 50% of the Federal minimum wage, the consumer may access Pre-Vocational Services for the next quarter. If the wage exceeds 50% of the Federal minimum wage, Pre-Vocational Services should be discontinued for the next quarter and the provider should request a budget for Sheltered Employment for that consumer for the next quarter. A one-for-one exchange of hours between the services is allowed. To increase above the one-for-one exchange in hours, a new budget must be prepared and submitted to the BDDS service coordinator and include justification	• Bulletin, 11-24-08, Page 8

	for the request or a Plan Update must be submitted by a case manager requesting an increase in Pre-Vocational service hours.	
Please explain the Pre-Vocational Service definition? It says that "the consumer is not expected to be able to join the general workforce or participate in sheltered work in the next year." However, I thought we were told that the determination of whether they are prevocational or sheltered work is their production % for the previous quarter.	The determination for the next year will be a predication based upon past experience. By Federal definition, you cannot have greater than 50% wage earnings and stay in Pre-Vocational Services. DDRS has decided that a quarterly review was a reasonable time to make changes. State Line will match hour-for-hour changes. DDRS will analyze the effect to the State Line budget in 6 to 9 months to ensure we are able to continue to provide this hour-for-hour exchange of Pre-Vocational for Sheltered Services.	• Bulletin, 11-24-08, Page 8

TOPIC: TRANSPORTATION SERVICES

QUESTION	ANSWER	RESOURCE
Is transportation billable as a service to consumers receiving more than 35 hours per week of RHS?	No. Transportation costs have been built into the RHS rate.	• Slide 59 • Bulletin, 11-24-08, Page 4
Are Transportation Services to and from day services included in the RHS rate?	Yes. Transportation Services are included in the RHS-2 expectations.	
Do Transportation Services have to do a service note?	Please refer to definitions sent in the November 7, 2008 Bulletin for documentation requirements for Transportation Services	• Bulletin, 11-7-08, Attached Service Definitions

Reference #: OA20081224